

RADIOLOGICAL EQUIPMENT SURVEY REQUEST FORM

Date: _____

From: _____ (Requesting Activity)

To: _____ (Regional Service Command)

Subj: REQUEST FOR RADIOLOGICAL SYSTEMS PERFORMANCE EVALUATION

1. Purpose ☐ Acceptance ☐ Periodic ☐ Situational

2. Point of Contact Information

Name: _____

Telephone Number: _____ FAX Number: _____

3. Equipment to be Evaluated

Equipment Type *	Manufacture and Model Number	Date of Last Evaluation	Significant Finding(s)

* Enter the following letter code corresponding to TYPE of radiographic equipment:

<u>Code</u>	<u>Equipment Type</u>
GP	General Purpose
FL	Fluoroscopy
TM	Tomography
CT	Computer Tomography
MA	Mammography
IO	Dental Intraoral
PN	Dental Panographic
CP	Dental Cephalometric
OT	Other (specify)

Name and Signature of person submitting request